

Reference Material 6-9  
**Work Experience Checklist - RN/LPN**

**Instructions:** check Hospital Unit box as applicable and insert date Month/Year to Month/Year.  
DO NOT USE "Present" or "Current".

**HEALTH CARE PROVIDER'S NAME:** \_\_\_\_\_

**HOSPITAL UNIT**

|  |   |    |   |  |   |    |   |
|--|---|----|---|--|---|----|---|
| <input type="checkbox"/> Burn                | / | to | / | <input type="checkbox"/> MED SURG        | / | to | / |
| <input type="checkbox"/> Cath Lab            | / | to | / | <input type="checkbox"/> Nursery         | / | to | / |
| <input type="checkbox"/> Dialysis - Hemo     | / | to | / | <input type="checkbox"/> Nursery Level 2 | / | to | / |
| <input type="checkbox"/> Dialysis Peritoneal | / | to | / | <input type="checkbox"/> OB              | / | to | / |
| <input type="checkbox"/> Dialysis - Renal    | / | to | / | <input type="checkbox"/> Oncology        | / | to | / |
| <input type="checkbox"/> ER                  | / | to | / | <input type="checkbox"/> OR              | / | to | / |
| <input type="checkbox"/> ER-Pediatrics       | / | to | / | <input type="checkbox"/> OR CV (CVOR)    | / | to | / |
| <input type="checkbox"/> Epidurals           | / | to | / | <input type="checkbox"/> ORTHO           | / | to | / |
| <input type="checkbox"/> Geriatrics          | / | to | / | <input type="checkbox"/> PACU            | / | to | / |
| <input type="checkbox"/> Home Health         | / | to | / | <input type="checkbox"/> Pediatrics      | / | to | / |
| <input type="checkbox"/> H/H Infusion        | / | to | / | <input type="checkbox"/> Private Duty    | / | to | / |
| <input type="checkbox"/> Hospice             | / | to | / | <input type="checkbox"/> Psych Adult     | / | to | / |
| <input type="checkbox"/> ICU-Adult           | / | to | / | <input type="checkbox"/> Psych Geriatric | / | to | / |
| <input type="checkbox"/> ICU - CV            | / | to | / | <input type="checkbox"/> Psych Peds      | / | to | / |
| <input type="checkbox"/> ICU - Neuro         | / | to | / | <input type="checkbox"/> Rehab Medical   | / | to | / |
| <input type="checkbox"/> ICU - Pediatric     | / | to | / | <input type="checkbox"/> Skilled Visit   | / | to | / |
| <input type="checkbox"/> L&D                 | / | to | / | <input type="checkbox"/> Trauma          | / | to | / |
| <input type="checkbox"/> LTC                 | / | to | / | <input type="checkbox"/> Telemetry       | / | to | / |

**SYSTEMS & PROCEDURES (Answer all questions):**

- Yes**    **No** Epidurals
- Yes**    **No** Fetal Monitoring
- Yes**    **No** Interpretation of Cardiac Dysrhythmias
- Yes\***    **No** Balloon Pump   \* \_\_\_\_\_ dates of experience
- Yes\***    **No** Online Charting: System used \* \_\_\_\_\_
- Yes\***    **No** Blood Glucose Monitor: Type \* \_\_\_\_\_
- Yes**    **No** The parenteral administration of electrolytes and fluids
- Yes\***    **No** Moderate sedation experience? If yes, How many months/years? \* \_\_\_\_\_
- Yes**    **No** IV insertion
- Yes**    **No** Phlebotomy
- Yes**    **No** Recognition of the need for psychological & social services for patients and their families

Employee Name (Printed) \_\_\_\_\_

Employee signature (or "via phone") and Date \_\_\_\_\_

Agency Name \_\_\_\_\_

Agency Representative Signature and Date \_\_\_\_\_